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ABSTRACT

Researchers have postulated that depression is the result of a number of factors. Theories include genetic, biological, psychoanalytic, behavioral, cognitive, and/or social stress factors as possible causes. Although all of these factors may be involved, the family is the setting in which the risk factors are actualized. Family factors have long been studied as relevant to the development of depression. A research review was conducted to examine the effect of family structures or relationships on the development of depression in children. The review, which focused on family characteristics that have been found to be empirically and theoretically related to the development of depression, found that multiple family factors may lead to the development of childhood depression. Depression has been demonstrated to be correlated with several family characteristics, suggesting that many components of family relationships may be responsible for the development of depression in an individual. Enmeshed families, triangulation, less rewarding and insensitive parents and role reversals all correlated with the development of depression in parent/child relationships. Families where there is marital instability, single-parent families, and families with a depressed parent or other family member were all found to be families at high risk for developing depression in their children. Structural family therapy, marital therapy and individual therapy are recommended as possible avenues for depressed individuals. (BHK)

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FAMILY RELATIONSHIPS AND CHILDHOOD DEPRESSION: A REVEW OF THE LITERATURE

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology

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In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

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by

Robyn Lisa Bettenhausen Geis

June 1990

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FAMILY RELATIONSHIPS AND CHILDHOOD DEPRESSION:
A REVIEW OF THE LITERATURE

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ABSTRACT

FAMILY RELATIONSHIPS AND
CHILDHOOD DEPRESSION

by

Robyn Lisa Bettenhausen Geis

The objective of this literature review is to determine how family structures or relationships contribute to the development of depression in children. Multiple studies on depression are used to determine the profile of a high risk family. Four main categories emerged as important factors. Family system variables such as enmeshment and triangulation increase the risk of depression in children. Certain parenting characteristics, including over-control and inconsistency, demonstrated a correlation with depression in chidren. Thirdly, depressed children were more likely to come from single parent homes or families experiencing marital conflict. Lastly, recurrent depression in a family member puts children at greater risk for depression.

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Family Relationships and Childhood Depression: A Review of the Literature

Introduction

Depression is a dysphoric feeling state in which a person experiences sadness, hopelessness, despair, and a loss of interest or pleasure in anything or anyone. This mood disorder affects the entire life and functioning of an individual. Certain authorities have claimed that at least 15% of all adults between 18 and 74 have experienced some form of depression severe enough to require clinical treatment (Beck, Rush, Shaw, & Emery, 1979). Another recent study by Lowry, Spinelli, & Lowry (1989-90) on the treatment of depression was funded by the National Institute of Mental Health (NIMH). The study, entitled Depression/ Awareness, Recognition and Treatment (D/ART), demonstrated that women are affected twice as often by depression as men. As of 1989-1990 12% of all men and 25% of all women in the United States have had or will experience depression. These rates have been steadily increasing since World War II. In addition, the D/ART study found that suicide has increased over 500% in the West since 1973. Although the elderly are considered to be at highest risk for both suicide and depression, researchers are finding that children and adolescents are also experiencing depression in increasing numbers (Lowry, Spinelli, & Lowry, 1989-90).

Researchers have postulated that depression is the result of a number of factors. Theories include genetic, biological, psychoanalytic, behavioral, cognitive, and/or social stress as possible causes. Although all of these factors may be involved, the family is the setting in which the risk factors are actualized (Schwab, Bell & Stephenson, 1987). Family factors have long been studied as relevant to the development of depression. Therefore, this paper focuses on family characteristics that have been found to be empirically and theoretically related to the development of depression. The parameters of the literature used in this review include all relevant journal articles available in Psychological Abstracts from 1984 through the fall of 1989, including as well other articles cited in its reference sections. Selected earlier material was drawn upon if pertinent to the topic. Any study providing information on depression in relationship to family members or family structure has been included in this review. Lastly, information has also been accessed from the 1989-1990 NIMH project, Depression/ Awareness, Recognition, and Treatment (D/ART). This program includes the most up-to-date information on the diagnosis and treatment of depressive disorders.

Lopez (1986) reviewed the literature available on family structure and depression. His study was done for the purpose of helping depressed college age clients. However, because his review is not exhaustive in its conclusions and scope, further material is addressed with the purpose of expanding his findings in relationship to children. In this paper, specific features of the family structure and its relationship to childhood depression are discussed together with a methodological critique of the studies available on this topic. Such features include parent-child relationship patterns, parental characteristics, marital instability, and the depression of one or more family

members. These family characteristics may be partially, if not entirely, responsible for the development of depression in an individual. This information is valuable for the future detection and prevention of certain risk factors related to depression. Due to the wide scope of the topic of depression, some of the studies may overlap in this literature review. Overall, the studies have been grouped according to their main findings. Before discussing these family predictors of depression, the next section summarizes methodological issues applicable to many of the studies reviewed here.

Methodological Issues

The most important issue to keep in mind while reviewing this literature is the possibility that the report of the depressed individual is more negative than it would be if he or she were not depressed. Many studies indicate that depressed people do not necessarily give an accurate, untainted report. For example, much of the literature suggests that a depressed person often internalizes a negative schema for viewing the world. This may be due to critical parents, bad experiences, or any number of other reasons. The depressed individual then evaluates future events based on this negative schema. Perhaps different conclusions would be reached if depressed subjects did not have negative dispositions biasing their reports.

Lewinsohn and Rosenbaum (1987) attempted to determine whether this negative schema or attitude was permanent or state dependent in the depressive person's memory. In the preliminary research, it was found that a depressed person's recall of parents was negative. However, subsequent analyses found that negative parental attributions occurred only for currently

depressed people and not for these depressed only in the past or in the future. A self-selected sample of 998 volunteers was divided into four groups according to their depression status: (a) depressed, (b) remitted depressed who had a history of depression but were not depressed during the study, (c) persons who became depressed during the follow-up period, and (d) never-depressed subjects (Lewinsohn & Rosenbaum, 1987, p. 611). The results indicated that recalling one's parents' behavior as rejecting and not loving is not a stable trait of depression-prone individuals. Only currently depressed subjects consistently described their parents "as having been more rejecting and using more negative-control techniques such as debasement and manipulation through guilt and anxiety" (Lewinsohn & Rosenhabum, 1987, pp. 611-612). Subjects who became depressed in a follow-up stage of the study did report negative memories of their parents at that time, although they did not report them as negative during the previous stages of the study.

Bower's (1981) findings supported the work done by Lewinson and Rosenbaum. In order to investigate the influence of emotions on memory and thinking, Bower (1981) conducted an experiment using college students. He found that subjects exhibited mood-state-dependent memory by having them recall word lists, personal experiences as recorded in diaries and childhood experiences. The results indicated that subjects recalled a higher percentage of those memories that were congruent with their current emotional state. For example, a sad subject would recall more sad material or identify more with the sad character in a story. Therefore, Bauer concluded that a depressed person would tend to recall only the unpleasant events and would project his or her resulting negative outlook onto the world.

The preceding authors were concerned that the data for studies on the relationship between family structure and depression were based on the recall of people who were already depressed. They raised two important questions: (a) How much of the depressed person's memory is reflecting reality? and (b)Are these memories stable or do they reflect the current mood state of the individual? These are important questions regarding the validity of any report of a depressed person and the ensuing information that may be applied for treatment of depression. This data should be kept in mind while reviewing the conclusions of this review.

The above information is a concern because the majority of research relevant to depression and family relationships utilizes self-report measures for its data. However, this type of measure is appropriate because clinical depression is defined largely by the client's report of how he or she feels. Although other measures can be used to assess the client's inner experiences indirectly, it is very efficient to receive a report directly from the individual.

Self-report measures do have certain limitations, however. One problem may be the idiosyncratic criteria that each individual uses while responding to a questionnaire. For example, what one person may define as "sad" may be quite different from the next person's interpretation of this word. The degree to which criteria and definitions vary from person to person will affect the accuracy of the measurements. It is difficult to determine if these differences are random or systematic, therefore some caution should be taken in reviewing results of self-report measures.

Self-report inventories may also include such problems as contamination due to subject biases and a lack of evidence that the instrument is measuring the characteristic of interest. The individual

responding to the self-report may answer in such a way that promotes his or her own interests or motives rather than what the researcher is intending to measure. For example, the extent to which individuals are seeking social approval may be reflected in the data obtained. Further response biases include exaggeration of the problem so the individual is assured treatment, agreement with all the items, choosing extreme responses, being overly cautious, or answering inconsistently across items.

A final aspect to consider with some self-report measures is the retrospective nature of the data. Retrospective data may be advantageous for many reasons, such as efficiency, measurement consistency, more options to investigate theoretically relevant events, and less subject attrition. Researchers also choose this method because it requires less time and money. However, retrospective methods may also leave room for social desirability effects or inaccurate recall of data. The data are affected by the amount of time between the event being recalled and the salience of the information being remembered. Events further in the past have a greater chance of being distorted than more recent occurrences (Featherman, 1980).

The present research on depression and family structure sometimes uses case studies as a method of gathering data. This type of data allows for observations of an individual or small group of people in greater detail so that the uniqueness of their situation is captured. The naturalistic and uncontrolled characteristic of the case study complements experimental research (Kazdin, 1980). Unfortunately, using the case study as a source of data also has some limitations. Many researchers consider the data from case studies to be scientifically weak. It is very difficult to control for alternative explanations of the results. Although case studies are used to suggest

etiological influences of a disorder, it is difficult to pinpoint the exact event(s) in an individual's life that have contributed to specific outcomes. Furthermore, as mentioned above, the report of one person is not always a reliable or valid source of information.

A further weakness is that the use of case reports may result in bias on behalf of the subjects or investigators. For example, the person recording the information, such as a therapist, may have biases or impressions of his or her own that influence interpretation of the data. These data may not be considered completely valid because of the subjectivity of the situation. Additionally, when an individual is reconstructing events from the past it is difficult to separate current emotional content from prior experiences. Therefore, the information may be tainted or distorted because of current intense emotions surrounding the situation being recalled. Overall, the absence of objective information creates a possible limitation to the validity of the case study and of retrospective data.

Finally, using the case study as a source of data may result in a lack of generalizability of these reports. It is important that the information obtained be applicable to other therapeutic situations. Because one individual's history may contain many differences and variations from that of the next person, generalizing from a case study to an entire population has limited utility. Of course, increasing the number of subjects may improve the validity of a study, but the findings must be shown to be solely attributable to the independent variable. Overall, most of the studies included in this review are not case studies and have an adequate sample size.

In summary, the important methodological issues to be considered in reviewing this material include the tendency of depressed people to view

everything negatively. This in turn affects their reports about their family of upbringing. The second issue involves the probability of response biases in case studies and in self-report data, especially retrospective data.

Family Correlates of Depression in Children

With these methodological problems in mind, the four familial correlates of depression found in the literature will be examined in detail. They include parent-child relationship patterns, specific parenting characteristics, marital instability, and depression in one or more family members. Each topic will be introduced followed by presentation of the supporting studies.

Parent-Child Relationship Patterns

Studies of the relationship between family structure and depression have indicated that a number of factors contribute to the development of depression in a family member. As of yet, it has not been proven that one characteristic alone is more important than other factors in contributing to depression development. Studies have indicated that the parent-child relationship is very important to the development or prevention of depression in an individual. The studies presented have focused on negative aspects of parent-child relationships that may contribute to depression. For example, parent-child over-involvement is a hindrance to the growth of family members. In this type of family relationship structure, there is not enough independence for the individuals involved. In these cases, the parents are so involved with their child's life that they overstep their boundaries to the point that the child may lose sight of what is the role of the parent and what is the role of the child.

Consistent with this view, Sullivan and Sullivan (1980) and Farley (1979) found that young adults who are physically separated from their parents are healthier and more affectionate, independent, and satisfied than young adults who live at home. Psychological health is said to be dependent on the individual family member's capacity to individuate from the family. If a family does not allow for the development of independence in an individual, the person would then likely experience anxiety as he or she approaches the tolerance boundaries of the family (Farley, 1979). The ability to detach from one's parents is paired with growth and better adjustment.

In the past, research has shown that mothers are more likely than fathers to be over-involved with their children as a result of the family structure. Minuchin (1981), a structural family therapist, has extensively studied the dynamics of enmeshment within a family system. Mothers tend to be the primary caretakers of children and therefore are more susceptible to becoming enmeshed with them. In this case, the parent usually feels insecure about himself or herself and is seeking self-fulfillment through the child. In Minuchin's opinion, over-involvement becomes a handicap because the child must forfeit his or her individuality and independence in exchange for an increased sense of belongingness. At some point, both family members involved in giving up some of themselves will become resentful and angry or be sentenced to live a life of dependence. Either way each member will eventually experience some degree of depression over the loss of self and independence. The result is a confusion of not knowing oneself due to a blurring of boundaries between important people in one's life. In other words, over-involvement between family members produces less distinction among the individual members.

Parents and children may also become involved in a pattern in which the roles of each family subsystem become reversed. Dependency needs within both the parent and the child cause role reversals to take place (Kreider & Motto, 1974). For example, one child may spend most of his or her time taking care of a needy parent instead of playing with siblings or friends. Such a parent absorbs the desired attention, rewards the child, and therefore perpetuates an unhealthy pattern. At some point, each member will realize his or her dissatisfaction with the unnatural roles, which may produce depression.

Lantz (1986) provided an example of role reversal in his research on families in which a depressed adolescent gets better. He found that a shift in family structure and roles occurs in these families. His results indicated that in three of the four families studied, when the depressed, parentified adolescent would begin to get better the parents would demonstrate an increase in depression. Lantz proposed that the increase in depression most likely resulted from the unbalancing of the unhealthy family system to a healthy one where the parent is forced to face his or her own pathology. Often individuals are too comfortable in their dysfunctional ways of interacting to want to change. They are unable to see the benefits of short term discomfort for long-term improved communication. Unfortunately, children often serve in a pathological role that prevents their parents from having to interact with each other and deal with their own pathology.

Parent-child role reversal may be a prevalent cause of adolescent suicide and depression disorders (Lopez, 1986). Although unverified, one may hypothesize that a suicide attempt may be a gesture on the part of the young adult to create a more appropriate relationship between parent and

child. In other words, the attempt may be a reaction to an inappropriate parent-child relationship. The individual may also be taking the ultimate victim position or helpless role through this action and is therefore assuming an exaggerated childlike position.

Parent-child relationships may also be marked by certain coalitions that take place in dysfunctional homes. Salvador Minuchin (1974) explains coalitions in the hypothetical example of an adolescent child and his mother. Before adolescence, the child has shared a special relationship with his mother that excluded the father or other members in the home. Upon reaching the age of independence and autonomy, the adolescent boy may begin to practice more independent behaviors. This becomes a potential threat to the mother who has invested a lot in this child. She may attempt to undermine the adolescent's autonomous behavior and try to keep him dependent because otherwise it forces her to communicate with her husband. Although coalitions are more common with mother-child relationships, it is possible that a father and his offspring could engage in the same pattern. What is most harmful about coalitions is that the child is forced to be a mediator or to side with one of the parents.

In agreement with Minuchin's theory, Bell and Bell (1982) and Teyber (1983) found that higher functioning adolescents were not involved in coalitions with their parents. Bell and Bell compared 95 families through interviews. The results indicated that the adolescent who tested to be more mature was also less likely to be triangulated into the parental subsystem either by acting as a scapegoat or as a mediator between the parents. Teyber also examined structural family relations to find which families produced better adjusted children. He found that for females there was a much better

rate of adjustment when the mother-father relationship was primary as opposed to a parent-child relationship being the most important. This hypothesis was not supported for males. In general, these findings indicate that healthy boundaries within the family can produce more healthy functioning in female children.

In his review, Lopez (1986) theorized that the child may experience much confusion when the dysfunctional family is dominated by the opposite sex parent because the child is torn between identifying with the dominant parent and identifying with the parent of the same sex. Lopez hypothesized that the sex of the dominant parent may be a predictor of future depression. In any case, Lopez believed on the basis of his review that "when the child does side with one parent against the other . . . [he or she] is at high risk for anxiety, depression, and maladjustment" (p. 509). In support of this hypothesis, Schwarz and Zuroff (1979) surveyed 98 college females who completed measures of depression, family conflict, and parental dominance. Results indicated a strong positive relationship between all of the above mentioned factors. Schwarz and Getter (1980) also found that the level of family conflict was a strong predictor of major psychopathology. These predictions were mediated by the sex of the student and the sex of the more dominant parent. In other words, neurotic females tended to have high family conflict in the context of a dominant father and neurotic males had high family conflict with the mother as the dominant parent.

The correlation between parent-child relationship patterns and depression may arise partially from aspects of parenting that are employed with the child. One such technique may be the method by which parents set standards for their children. Most parents set high standards for their

children but the difference between a depressed child's family and that of a non-depressed child's family may be the rate of reinforcement that accompanies the high goals. If a child does not receive a considerable amount of positive reward, his or her level of interest in attaining the high goals will not be maintained. Rather, the child's self-esteem decreases. This in turn may lead to life- long patterns that perpetuate a depressive affect. In other words, the child learns to set high standards for him- or herself and then to be restrictive with the amount of self-praise awarded (Cole & Rehm, 1985).

These conclusions are supported by the research of Cole and Rehm (1985) on 45 families. The Children's Depression Inventory, the Schedule for Affective Disorders and Schizophrenia, the Beck Depression Inventory, and personal interviews were all administered in order to determine the relationship between family interaction patterns and childhood depression. The results showed that depressed subjects received a significantly less amount of positive reinforcement than non-depressed subjects. Furthermore, all families gave evidence of setting high standards for their children, but depressed families were more likely to have difficulty maintaining high levels of positive reinforcement while setting high standards. The measures also indicated that depressed subjects would set and maintain very high standards for their own performance compared to the non-depressed children.

Parent-child relationship patterns may also be marked by the level of openness the parent has to recognizing problems in the child. It has been found that parents often are unaware that their child is feeling depressed (Angold et al., 1987). If the children said they were not feeling depressed, then the parents also reported no depression in the children. The only

discrepancies occurred when the parent would not report awareness of a depressive symptom that the child claimed to have (Angold et al., 1987). In summary, agreement between parent and child was strongest when the parent either agreed that depression was present or agreed that the child was functioning well enough at the time. Disagreement occurred only when the parent did not recognize depressive symptoms in the child. As a side note, it is interesting that the authors suggested the disagreement may be due to the parents' unwillingness to face their own depression or their desire to cover up any serious problem that may be present in the family.

Keitner et al. (1987) also addressed the parents' openness or ability to detect their child's problems by comparing suicide-attempting and nonsuicide-attempting depressed inpatients. The suicide-attempting depressed patients perceived their families less favorably than the family members perceived themselves. The discrepancy between suicidal teenagers and their parents' perceptions was greater than the discrepancy between depressed, non-suicidal teenagers and their parents. This finding implies that the suicide-attempter may be the scapegoat for the family and therefore quite possibly the only member who is consciously aware of or recognizing the dysfunction. Furthermore, if scapegoating does occur in depressive families it demonstrates a lack of sensitivity on the part of family members. Once again, if an individual is experiencing some anger or frustration and does not have the resources or permission to express this within the family, the negative feelings will most likely be turned inward creating depression. However, the findings of Lewinson and Rosenbaum (1987), as stated earlier in this paper, indicated that the suicidal person may be more negative due to his or her depressive state. If this were the case, then increased negativity might

increase both the risk of suicide and the discrepancy between their own versus their family 's impressions of themselves. However, the question of the etiology of the depressed person's negative outlook has yet to be answered.

In summary, depression in children has been shown to correlate with certain parent-child relationship patterns. Parental over-involvement, also referred to as enmeshment, puts a child at greater risk for depression than the child who is free to individuate from the family. Another common relationship pattern in families that are at high risk for depression is the occurrence of role reversals, that is, where the roles of family subsystems become reversed. For example, the oldest sibling may act as a parent to other siblings or to the actual parents (i.e., the child taking care of an alcoholic parent). Coalitions were also demonstrated to be present in dysfunctional homes. In this case, either parent may side with a child against the other parent creating an imbalance in family relationships. Parents of depressed children also tended to have low reinforcement rates in rewarding their children. Lastly, the literature suggests that a lack of awareness of the parents to their child's problems may also give rise to childhood depression.

Parenting Characteristics

As shown above, certain parent-child relationship patterns may indicate a high risk for depression in a child. On the other hand, a number of studies have indicated that specific parenting characteristics may contribute to the development of depression in their children. The research suggests that a general profile of parenting characteristics identifies the kinds of parenting styles that are at greater risk for developing depression. More specifically, the literature on parental characteristics may be divided into two categories:

(a) nurturance and (b) control-oriented characteristics. The next section summarizes associations between parental nurturance and depression in children, followed by a discussion of parental control and depression.

Most studies examined the parenting characteristics of the mother. There is far less information available upon which to build a profile of the father of a depressive family than there is on a mother. Even though there is a dearth of information on fathers, there are still a number of studies that claim the father-child relationship is important to the overall development of the adolescent, especially the female adolescent (Baron & MacGillivray, 1989; Blatt, Wein & Chevron, 1979; Brook & Brook, 1983; Brook, Brook, Whiteman & Gordon, 1988; Raskin et al., as cited in Burbach & Borduin, 1986; Schwarz & Zuroff, 1979).

Nurturance oriented characteristics. A review by Burbach and Borduin (1986) uncovered several aspects of the parent-child nurturance relationship that may be conducive to depression. Some of the correlations with depression found in this review included less positive parental involvement with their children, low levels of maternal nurturance and support, negative evaluations from parents, and withdrawal of affection.

In a study of 121 students, Blatt, Wien, and Chevron (1979) also found a relationship between parental nurturance and child depression. Students who described their parents as lacking in nurturance, support, and affection also demonstrated a greater chance of having a depressive profile.

Another trait of mothers with depressed children is that they are less likely to express positive affect. It has been shown that mothers of depressed children set higher performance standards for their children and reward them at a lower rate than mothers of non-depressed children (Cole & Rehm,

1985). In other words, these children are receiving much less positive reinforcement and nurturance than children who are not depressed.

In a study by Brook et al. (1988), 403 female college students and their fathers participated by completing questionnaires. Separate scales were developed for fathers and daughters. The scales for the fathers had reliabilities (Cronbach's alphas) ranging from .44 to .84 with a mean of .60; the scales for the daughters ranged from .23 to .91 with a mean of .58. The daughters' depressive mood was measured with the Hopkins Symptom Checklist which had a Cronbach alpha of .78. Significant relationships were found between depressive mood in the daughter and paternal insensitivity (i.e., interpersonal difficulty) and poor paternal psychological adjustment (i.e., lower self-esteem). Furthermore, the depressed daughters tended to have fathers who had difficulty establishing affectionate relationships and were less emotionally as well as physically available. If the father was more rejecting than accepting, the child would develop a sense of worthlessness, which is a precursor or component of depression.

Baron and MacGillivray (1989) and Schwarz and Zuroff (1979) also found that depressed adolescents reported their fathers to be more rejecting and indifferent than did the non-depressed subjects. Inconsistent love from the father in a paternally dominated home was associated with greater vulnerability to depression (Schwarz & Zuroff (1979).

Schwarz and Zuroff investigated family structure and depression in 98 female college students. The Beck Depression Inventory, a validated Schwarz-Getter Interparental Conflict Scale, the Lanyon Psychological Screening Inventory, and the Siegelman-Roe Parent-Child Relations Questionnaire were all used to draw their conclusions. Daughters from low-

conflict homes with dominant and consistently nurturing fathers were shown to be least vulnerable to depression.

Through examining depression and its social-cognitive correlates in 108 elementary school children with a cross-sectional design, Kaslow, Rehm, and Siegel (1984) found that depressed children perceived their family environment to be more distressed and less nurturing. As a result of their findings, these authors theorized that interpersonal contexts, such as family and parental capacity for nurturance, play a crucial role in the development of affect.

Cole and Rehm (1985) studied 45 family triads to determine the effect of family interactions on childhood depression. The volunteer families were selected from a small population of child guidance centers and divided into two groups (depressed and non-depressed) according to the diagnosis of the child. Diagnostic information was obtained through the Children's Depression Inventory (Kovacs & Beck, 1977), Beck Depression Inventory (Beck et al., 1961), and the SADS (Endicott & Spitzer, 1978). Blind interviewers also administered a task for the family to accomplish together. The results indicated that parents of depressed children rewarded them less than did the parents of non-depressed children. In fact, the mothers of depressed children were half as likely to express positive feedback to their children as were the other mothers in the sample. The fathers of depressed children were also less positive toward their children, although the difference did not quite reach significance statistically. However, it should be noted that because the children in the experimental group were depressed their behavior may have been less "rewardable" than that of the control children. The depressed children may have been less active, therefore providing less

opportunity for the parents to reward them. Perhaps if the researchers had observed the percentage of times the parents were rewarding of positive behaviors the differences between groups would not have been significant.

Lewinsohn and Rosenbaum (1987) found that their acutely depressed subjects did report their parents to have negative parenting styles and to be "emotionally rejecting" (Lewinsohn & Rosenbaum, 1987). No significant differences were found between mothers and fathers. However, an important finding of this study is that negative memories are not a stable trait of individuals who have experienced multiple episodes of depression. Therefore, subjects who were currently depressed responded that their parents were negative and rejecting, whereas the depressive subjects in remission responded in a similar manner to those subjects who had never been depressed. This raises questions as to the role of parental representations in the etiology of depression.

Control-oriented characteristics. Not only is low nurturance associated with depression, but the literature indicates as well that over-control in mothers can lead to adolescent depression. Baron and MacGillivray (1989) evaluated 208 adolescents and their relationships to their parents. The mother's psychological control was found to be a powerful predictor of adolescent depression. However, it should be noted that it is possible the depressed adolescent might be eliciting the over-controlling behavior from the mother. The above findings are also supported by Burbach and Borduin's (1986) review. They concluded that correlations with depression include high maternal overprotection and negative child-rearing strategies.

One study established that paternal control and depressive mood in daughters does have a significant positive relationship (Brook et al., 1988,

p.488). These authors utilized canonical correlation analysis to examine which paternal characteristics were related to daughter personality sets. The highest significant correlation between the father-daughter relationship variables and the father-daughter canonical variate included the daughters' resistance to paternal control (.77) and more extreme autonomy (.23). From these data the author concluded that over-controlling parents have a greater chance of observing a personality disturbance in their child.

A final study on this topic was done by Birtchnell (1988). In this study, the depressed women reported that their early relationship with their mothers as not positive but rather marked by low care or overprotection compared to the non-depressed women. This was also found to be true of the subject's relationship to her father. All the depressed women stated that they currently had poor relationships with their husbands as well as with their in-laws. The authors explained that the subject's poor early relationship with their mothers most likely contributed to a vulnerable personality in the female. This personality type would be susceptible to depression and to an inability to perform satisfactorily in adult relationships.

In examining this literature it is evident that both a lack of nurturance and excessive control by the parent cause a greater risk of depression in children. However, since most of the data obtained in these studies was through self-report it is important to remember that research does indicate depressed persons have somehow developed negative schemata in their method of thinking. These schemata currently influence how they evaluate themselves, the environment, and both the past and the future. However, memory can be affected by more than one's current affective state. Other people or situations may explain the differences in memory recall as well.

As has been shown, parenting characteristics play an important role in the development of depression in children. Parents lacking in affection and the capacity to give positive feedback tended to produce more depressed children than parents who were able to provide support and affection. Parental rejection played a very important role in developing depression in children. Furthermore, over-controlling parents were consistently found to have more depressed children than parents who were comfortable with their child's growing autonomy.

Marital Instability

Along with certain parent-child relationship patterns and parenting characteristics, a further indicator for higher risk of depression in children may be seen in the quality or stability of the marriage. Family structure is certainly dependent on the state of the parents' relationship. In the following section, such factors as single parent families, marital distress, or marital conflict are discussed in respect to their contribution to depression in children. The material is divided according to marital quality and structure.

Quality of the marriage. It has been suggested that when parents are frustrated with their marriages and fighting occurs, parenting is compromised first (Emery et al. as quoted in Stoneman et al., 1989). When a lack of security exists in the marriage due to conflict, there is a strong negative effect on the entire family (Stoneman et al., 1989). In their study of 47 intact families, Stoneman et al. investigated whether a relationship exists between marital quality, depression, and inconsistent parenting. Only mothers were observed while interacting with their children, but both parents participated in completing the questionnaires and tests. The results indicated that parents with happier marriages reported less conflict in front of their children. In

their discussion, the authors speculated that the distress the parents are experiencing may cause them to put less effort into their parenting by choosing more immediate procedures and thinking less about discipline. Lastly, this lack of consistent guidance on behalf of the parents was shown to cause distress in the young female member of the family and aggression in the young male.

Marital satisfaction has also been shown to be strongly correlated with maternal depression. The positive quality of the marriage decreases with the presence of depression in one or both parents. One study investigated how maternal depression affects problem solving interactions with husbands. Biglan et al. (1985) studied 52 married couples and found that the depressed women in these couples were less able to problem solve than their husbands and the combination of the depressed wife and her husband was less apt to self-disclose in their communication than were the control couples. This will more than likely affect their parenting skills. At the very least, it would decrease the couple's ability to come to an informed strategy for dealing together with parent-child issues and therefore would create a higher risk of insecurity and depression in the children. Unfortunately, if the quality of a marriage is extremely poor then the structure of the family likely to be is affected negatively. The next section examines how family structure contributes to childhood depression.

Structure of the family. Enos and Handal (1986) conducted a study on the relation of parental marital status and perceived family conflict to adjustment of adolescents. Using a sample of 823 voluntary white adolescents between the ages of 13 and 18, the Family Environment Scale (FES) was administered to determine the adolescents' perception of the family

climate. The Langner Symptom Survey (LSS) and General Health Questionnaire aided in determining the psychological adjustment of the subjects. The results showed that adolescents from intact homes experienced greater cohesiveness ($p < .02$) than adolescents from divorced homes. Post hoc analyses using Scheffe´ tests indicated that groups of adolescents experiencing family conflict differed significantly from adolescents with average psychological adjustment in their perceived family climate and on the measures of psychological adjustment. This supported the authors' psychological-wholeness position, which stated that "the presence of perceived current conflict within a family, regardless of parental marital status, has an adverse effect on adjustment" (p. 822). In other words, divorced, conflictual homes produced poorer psychologically adjusted adolescents than did non-conflictual, intact homes. The results of this study provided strong support for the notion that adolescents' psychological adjustment and satisfaction with their social life has a strong relationship with their perceived level of family conflict.

Single-parent families also may have an increased risk of depressed children. Feldman et al. (1986) conducted a study of 103 sixth-graders on the relationship of depressive affect with family structure and family process. In this study, the authors identified a high risk group for depressive affect: adolescents who come from single- parent homes and do not have a strong support group of friends. Children from divorced homes experienced more stress in daily living, had more emotional difficulties, and had a lower self-esteem. The study did not indicate how long after divorce these things occurred. The combination of these factors produced a higher risk of

depression in these family members as compared to children from two-parent families.

Usually single-parent families consist of a mother and her children. Therefore, mothers have been generally accepted as the primary parent involved with the child. As a result of this phenomenon, father absence has been shown to have a profound impact on the development of the children. Girls from father-absent homes tend to be more dependent, have unstable relationships, experience insecurity in interacting with males, and overall feel a lack of control over their lives (Hetherington, 1972). It should be noted that daughters from divorced homes generally take more initiative in relationships with males, possibly to the point of promiscuity. It is the daughters of widows that experience more shyness and reticence in initiating relationships with males.

In conclusion, it was found that both the quality of the marriage and the structure of the family play a significant role in children's depression. High levels of conflict and marital distress were shown to contribute to depression in children. Furthermore, single-parent or father-absent homes were shown to be more conducive to depression in children than intact homes.

Recurrent Depression in any Family Member

Marital discord may contribute to depression, particularly in the mother, and this in turn will have an effect on the children. However, a parent may be experiencing recurrent depression for a number of reasons, such as genetic causes, situation-specific stresses, chemical imbalances, or marital difficulties. In any case, parental depression increases the risk for child depression. In the following section the effects of general family

depression on children will be reviewed at followed by a discussion on specific maternal depression influences.

Studies of families have found that depression in parents contributes to the transmission of familial depression and aggression. This problem stems from the impairment of child-rearing methods in depressed parents, sometimes resulting in abuse and/or neglect of the children. At this point, the abused or neglected child will either externalize the anger and feelings of helplessness into aggression, or internalize them as depression (Sturkie & Flanzer, 1987). Interestingly, Sturkie and Flanzer (1987) conducted a study of 65 families, with both clinical and control groups, and found that aggression and depression differences between the two groups were more quantitative than qualitative. In other words, the authors claimed that patterns in client families merely represent an exaggeration of the patterns in normal families. Depression in a family member may amplify the apparent level of aggression and depression already existing in a family system.

Major depression in the family may greatly impact family functioning. A study by Keitner, Miller, Epstein, Bishop, & Fruzzetti (1987), found that families with a depressed member, whether during an acute episode or in remission, reported significantly worse functioning than the control families. This study analyzed 38 depressed inpatients and their families as well as 124 non-clinical families to determine the effects of depression within the family. Not only did the depressed families report significantly worse functioning, but it was also found in the follow-up that although the depression typically improved, the depressed family would still report their lives to be more problematic than did the control groups. This provides support for either the role of the family in the etiology of depression or the role of depression in

family problems. Perhaps one explanation for the former notion is that the depressed family inadvertently teaches its members to perceive the world negatively, as has been suggested before. On the other hand, depression may be a primary cause of problems in the family.

More generally, an individual's recurrent depressive disorder causes serious difficulty in the lives of that person's immediate family members. Jacob et al. (1987) evaluated 128 depressed patients and their families and found that the strain of familial depression may cause such difficulties as (a) long-term emotional burdens, (b) chronic marital disharmony, (c) social isolation, (d) chronic tension, and (e)fear of the disease recurrence. Having a family member with a recurrent depressive disorder puts an extreme burden on the family. Jacob, Frank, Kupfer, & Carpenter (1987) confirmed this by finding that the the control group individuals suffered a significantly lesser amount of difficulties than did the families living with a depressed patient.

The risk of having a significantly depressed person in the family is increased by poor family relationships. This correlation has been demonstrated by Birtchnell (1988) in a study he carried out on 50 depressed and 40 non-depressed English women. In Birtchnell's research, depression screening instruments were administered in two health care centers to all consenting, married women between the ages of 25 and 34 years old. All participants were from a local, "expanding" housing estate. Data were collected over 30 months and then only the "high-scorers" above a pre-determined cut-off point on a depression screening instrument were included in the depressed group. Three interviews were conducted with the woman alone, the husband alone, and the couple together. The instrument used to measure depression was validated appropriately with 103 depressed

psychiatric patients and in conjunction with the Beck Depression Inventory. The results indicated that both early and current relationships of depressed women were reported to be generally worse than those of the control women. The authors suggested that poor early relationships may contribute to developing a vulnerable personality, which has an increased proneness to depression. They stated that it is likely that from an early age a vicious cycle begins with depressed parents, who have a greater chance of raising depressed children.

Extensive research has been done specifically on maternal depression and its effects on family members. Some researchers believe that there is possibly a strong relationship between maternal depression and child rearing problems. Fergusson et al. (1984) conducted a longitudinal study on 1,265 children. The sample included children of both depressed and non-depressed mothers. Information regarding health, social background, and family conditions was gathered from the mothers by the investigators at birth, four months, and annual intervals until the age of five. The Levine-Pilowsky questionnaire was used to determine maternal symptoms of depression. Women reporting a significant amount of depressive symptoms on the Levine-Pilowsky questionnaire also reported significantly more child-rearing problems than did the mothers who reported no depressive symptoms. Depression and number of negative life events were significantly correlated ($p < .0001$) as well as depression and maternal reports of child rearing problems ($p < .0001$). The authors concluded that depression has an effect on child rearing difficulties, and they proposed two theories to account for this pattern. One theory states that maternal depression actually produces an increase in child rearing problems. The second is that maternal depression

alters the way in which the mother perceives her child's behavior. In either case, it is evident that the mother's ability to meet the child's needs is impaired by the depressive disorder.

Another study also concluded that depressed mothers may be experienced as having a rejecting attitude toward their children. In this study of 56 mother-child pairs, Field et al. (1987) found that children of depressed mothers reported their mothers to be withholding and ignoring compared to children of non-depressed mothers. This was evidenced in the mother's lack of involvement in the child's free play. The depressed mothers also were considered to be less responsive to the demands of the child.

Taking the above information one step further, Hughes (1984) added that childhood depression may be a reflection of maternal issues of depression. In his study of children with recurrent abdominal pain, Hughes discovered that "the mother-child relationships were shown to reflect mutual themes of depression" (p.146). In interviewing the children, the researchers found that anger and resentment were difficult for the children to acknowledge and that they were very aware of their mother's somatic problems. An interesting note in this study is that while the children were hospitalized and away from their families, they all showed an improvement in their stomach complaints, were affectively happier, and displayed fewer depressive symptoms. However, after the parents would visit it was not unusual for some of the children's symptoms to recur. Hughes theorized that the child learns and is reinforced from the mother to express depression indirectly such as in the case of the mother's hypochondriasis. A further difficulty is that a depressed mother is focusing on her own needs so much

that she becomes insensitive to the child's needs and is therefore unable to meet them.

With the father of the family absent, the mother also feels a lack of support. Therefore, it comes as no surprise that when the mother of a family is experiencing some effects of marital instability or distress she is more at risk for depression. The resulting depression affects all family members, especially the children. The mother will tend to express a more dysphoric affect and have a less positive emotional influence on her children. In a review of the literature, Schwab et al. (1987) concluded that depressed mothers have difficulty providing emotional support for their children. As a part of this cycle, a mother in turn will feel guilt, hostility, and resentment which is reflected not only in her relationship with her husband but also with her children.

Lastly, it has been shown that families with mothers experiencing depression as a result of marital discord tend to follow a suppressive interaction pattern. This means that the depression of one member may cause the affect of the other members to be suppressed. One explanation may be that the other family members put the needs of the depressed person above their own. Hops et al. (1987) investigated 27 families with depressed mothers and found that the mother's depressive affect suppressed the aggression of the other family members, whereas the aggression of other family members was able to suppress the mother's depressive affect as well. For example, if a child were to become angry with the mother, the child would not express this anger for fear of upsetting the depressed mother and causing further damage. Therefore, Hops et al. concluded that marital discord contributes to the mother's depression and this exacerbates communication problems in the

family, causing a greater risk of dysfunction in the family members, especially the children.

Unfortunately, depression affects how an individual relates to others and this in turn will cause more depression, thereby continuing a vicious cycle. As mentioned before, one difficulty to keep in mind while evaluating these studies is that the recall of depressed people may be tainted by their depression and the information obtained from them may not be completely accurate.

In summary, depression in other family members has been shown to affect the development of depression in children. This can be done through direct transmission or internalization of the parental depression. Parental depression may also indirectly contribute to childhood depression by retarding the family functioning capacity. Depressed parents were shown to be less capable at child-rearing than non-depressed parents. Lastly, maternal depression had special mention because of the vastness of the literature available on this topic. The conclusions were that depressed mothers demonstrate child-rearing problems, are more rejecting towards their children, and tend to create a pattern of suppressive interaction in their families. In other words, because one member of the family is depressed the needs of the other family members are not recognized as equally important.

Conclusions

The literature indicates that multiple family factors may lead to the development of depression in an individual. Depression has been demonstrated to be correlated with several family characteristics. Many components of family relationships may be responsible for the development

of depression in an individual. The research on parent-child relationship patterns indicates a number of factors that may correlate with the development of depression: (a) families with overly enmeshed relationships, (b) triangulation of parents with a child, (c) less rewarding and insensitive parents, and (d) role reversals. It was also found that when the parent does not allow a child to appropriately develop independence, that child may develop depression.

The presence of marital instability may be another indicator of families at high risk for developing depression in its members. Specifically, the literature reviewed in this paper indicates that either single-parent families or families experiencing a high degree of distress due to marital conflict will have a greater chance of developing depression in the younger family members.

Studies that examined how depression in a family member affects the other family members also pointed to a relationship between depression and family structure. If a particular family is composed of one or more depressed persons it is likely that some dysfunction will occur in the children. Parental depression demonstrated a particularly strong correlation with depression in children. Overall, families with depressed members reported poorer family relationships than families without depressed members.

Parent personality and interactive style is perhaps one of the more important indicators of families with a high risk for depression. Although all of the studies included in this review investigated characteristics of mothers and fathers separately, it does not indicate that no overlap exists. In other words, what has been found to correlate with depression in the maternal characteristics may also be true for paternal influences. For example,

rejecting, negative, and over-controlling mothers were more likely to have depressed children than mothers who did not demonstrate these traits. The research available on fathers' relationship to their children was not as extensive. However, some overlap was found. Rejecting, insensitive, unavailable, and inconsistent fathers were reported to have a greater chance of having depressed children than fathers who were not reported to have these characteristics. Future research on each of these specific factors would provide further evidence of the effect these specific parental characteristics have in the development of depression.

The correlations or causal influences mentioned above have been considered separately, but any combination may appear in the history of a depressed person. In other words, multiple risk factors increase the likelihood of depressive symptoms. Furthermore, this list of symptoms may not be comprehensive in that other factors as well may be included as correlates or influences of depression. Although studies from the past are used to generate new experiments and theories, the articles included in this review cover a limited period of research.

The conclusions derived from this review have been considered in light of certain methodological issues. It is important to note the influence of self-report measures on the outcome of the research. Using case studies and retrospective data also imposes some limitations as to the generalizability of their results. Also, the majority of studies of depression and family structure rely on correlations from which to draw their conclusions, meaning that causation is not necessarily demonstrated. Most importantly, when reviewing the literature on depression, it must be kept in mind that depressed people have been shown to be negative about everything. This

might better explain the correlations found in the studies rather than attributing the negative characteristics to the parents.

In spite of the high risk of depression in the above mentioned profile of families, certain methods may be used to correct or prevent this developmental process. Minuchin has proposed structural family therapy techniques for dysfunctional families. With this type of therapy, a depressed family may learn how to define the various boundaries within the family system. Boundaries are the distinctions made between individuals or subsystems within a greater system. For example, depressed children may learn that they have been inappropriately acting as a parent in the home, and they may have become depressed as a result of the lost childhood they are experiencing. The learning of each member's position and function in the family systems will provide security and a basis for more appropriate and healthy interactions.

Structural family therapy not only defines each member's position in the family but also emphasizes family strengths. A major problem with families today is the focus on the negative. Families are so aware of their problems that they lose sight of their strengths. Re-introducing the positives of a family may balance the amount of negativism present. This may alleviate or prevent the occurrence of depression.

A second aid for depressed families may be marital therapy. It is often the case that parents are uninformed as to their roles both as marriage partners and as parents. This may be due to the dysfunction of their own families of origin. Whatever the etiology, providing a couple with the proper information as to how to communicate in a marriage or to learn appropriate parenting skills may be helpful. If the parents are better informed

and more aware of their own shortcomings this will lead to a strengthened parental subsystem and result in greater direction and stability for all family members.

Lastly, but equally important, individual therapy remains a viable option for a depressed person. In most cases the depressed person will likely begin individual therapy before the family chooses to become involved. Many times an individual experiencing depressive affect will need to work on building up his or her own strength and self-understanding before approaching the family. Having family members in therapy may be a distraction and may perpetuate the dysfunctional interactional patterns instead of alleviating the depressive symptom. Timing in the inclusion of families in therapy is important. Furthermore, other family members may have been affected by the present depression in the family and may also benefit from individual therapy .

It is important to also mention the Mountain West Training in the Treatment of Depression study, entitled D/ART (i.e., depression /awareness, recognition, and treatment). As mentioned earlier, this project is the most current study on depression and was initiated to examine the effectiveness of specific forms of brief (16 weeks) psychotherapy on non-bipolar and non-psychotic depression. Both Cognitive Behavior Therapy and Interpersonal Psychotherapy were investigated in the D/ART study. The therapies were evaluated against the effectiveness of a standard antidepressant drug, imipramine.

The multi-site study utilized 250 outpatients who were randomly assigned to four treatment conditions: (a) imipramine alone, (b)Interpersonal Psychotherapy, (c) Cognitive therapy, and (d) a placebo group. Assessments

were taken at eight, twelve, and sixteen weeks. Their findings were that no significant differences existed in the relative effectiveness of the three treatments. All subjects indicated improvement from pre-test to post-test. Imipramine, however, does have a quicker effect, but all methods were shown to have equivalent results by the sixteenth week. Therefore, Interpersonal Psychotherapy, Cognitive therapy, and antidepressants are all effective means of treating depression and should be considered when assessing the needs of an individual.

The purpose of this review of the literature was to uncover the profile of a family at high risk for developing depression in their children. Information derived for the review may be useful to young adults who are planning families and who want to know how to be good parents. By looking at some of these factors, perhaps adults may avoid some of the pitfalls of poor parenting. Unfortunately, most individuals find themselves already depressed and unable to break out of old family patterns. The present paper also provides valuable information for the person seeking help for depression by reviewing the factors and learning which may apply in the individual's experience. Knowing past connections to present problems is a very healing process over time. Both the depressed individual and the treating psychologist can work together on the meaning of these various family attributes and how they are played out in the his or her current life situation.

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